Registration Form

(Participant)

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| Please fill the form with necessary information and email it at techhighed@gmail.com  |
| Participant’s Information  |

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Designation/Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Fee Submission Information |

Fee Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fee Submission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receipt Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bank Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Bank Name** | **Title** | **A/c No** | **Currency**  |
| Askari Bank | Air University Fazaia Medical College | IBNK61ASCM0007050370000401 | USD |
| Faysal Bank Limited | Air University | 3024436000049034 | Rupee  |